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BRIEF HISTORICAL PERSPECTIVE

Medical eponyms

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Eponyms are a long-standing tradition in medicine. Eponyms usually involve honoring a prominent physician scientist who played a major role in the identification of the disease. Under the right circumstances, a disease becomes well known through the name of this individual. There are no rules on eponym development. It may take an extraordinary period of time, be different in different languages and cultures, and evolve as more is known about the physician or the disease.

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Eponyms are a long-standing tradition in medicine. Eponyms usually involve honoring a prominent physician scientist who played a major role in the identification of the disease. Under the right circumstances, a disease becomes well known through the name of this individual. It is often easier to remember a disease by its eponym than by the more scientific pathologic description; for example, which name is better known, Hodgkins disease or any of its five types, to wit, nodular sclerosing, mixed cellularity, lymphocyte depleted, lymphocyte rich, and nodular lymphocyte-predominant?

The naming process usually begins when popular attention is drawn to an entity, not necessarily for the first time. In fact, the physician scientist whose name becomes the eponym is often distinguishable from other parallel observers for reasons other than being first. It may be the individual's reputation, standing, accuracy, details contained in the report or publication, or a fortuitous rediscovery often decades later by someone who then associates the disease with one or more of the earlier physician scientists. Sometimes luck plays a major role. There are no rules on eponym development. It may take an extraordinary period of time, be different in different languages and cultures, and evolve as more is known about the physician or the disease.

How many medical eponyms are there? There are medical eponyms for physical signs, tendons, reflexes, palsies, cysts, choreas, aneurisms, contractures, and many others. Some have estimated more than 8,000 (1). There are single name eponyms and multiple individual eponyms. There are possessive and non-possessive forms (2). When there are multiple names to the eponym, it is often interesting to assess how the order was adopted. It may be individual prestige, departmental seniority and, no doubt, could involve some bullying. Or it may be as simple as drawing straws or the famous Watson–Crick coin flip – won by Watson.

Eponyms can take decades to be commonly accepted, which is not necessarily a bad thing. Many eponyms have been identified after the death of the eponym namesake, when rediscovered by a secondary investigator who posthumously connects it with the individual who 'wrote it up'. Eponyms often reflect the dominance of scientific cultures and languages at the time. Eponyms flourished from the late 19th to early 20th centuries when the leading scientific languages were English and German. A good example of the eponym process is the entity of acute adrenal failure secondary to meningococcemia, referred to as adrenal apoplexy. Numerous case reports of this entity were published around 1900 mostly in obscure medical journals following autopsies that revealed adrenal (or 'suprarenal') fatal hemorrhage complicating sepsis (3). In 1911, British physician **Rupert Waterhouse** published in *Lancet*, the leading English language journal at the time, a fulminant fatal case report (4). In 1917 and 1918, **Carl Friderichsen** published two cases and a review of the literature in Danish and German (5). In 1933, Eduard Glanzmann, in a clinical review, gave it the name of Waterhouse–Friderichsen syndrome (6).

In the remainder of this perspective, we will review 10 eponymous medical diseases or syndromes. I believe eight are here to stay. The last name alone suffices, often not needing a word-like syndrome or disease to clarify. Two others are famous, if not infamous, and not only are

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fading away but there are active campaigns to erase them from memory, demonstrating that the slow approach may be the wise way to go, not unlike the rule that a player is not eligible to be elected to the Baseball Hall of Fame until 5 years after retirement.

James Parkinson was born in London in 1755. His initial professional interests were primarily in politics. He was an anti-Pitt government activist and was even questioned as part of the investigation of a rumored conspiracy to assassinate King George III after America was victorious in its war of independence. After turning to medicine, he became known for his observational skills and clarity of writing style. In 1817, he published an 'Essay on the Shaking Palsy', described as 'paralysis agitans' (7). Parkinson was 62 when he published this paper. He would die 7 years later. Approximately 60 years elapsed before famous French pathologists Charcot and Trousseu (themselves eponym namesakes) attached Parkinson's name to the condition (8).

Thomas Hodgkins was born a Quaker in England in 1798. Not surprisingly, he developed strong opinions as an adult against servitude and slavery. As a physician at Guys Hospital in London, he was a contemporary of Thomas Addison and Richard Bright. Guys Hospital was the epicenter of eponyms. Hodgkins was fortunate at least twice in the development of the Hodgkins eponym. His original descriptive paper was published in 1832 (9). Read and referred to by his colleague, Richard Bright, he published these reviews in 1838, but did not become widely known. In 1856, Samuel Wilkes reported similar lymphadenopathy and splenomegaly, initially believing he had identified something new (10). Wilkes, before publishing, discovered Bright's reference to Hodgkins' findings. The best he could say was that he rediscovered what Hodgkins had discovered 27 years before.

Robert James Graves was born in 1796 in Dublin. He was known as a polyglot as well as a physician. As a physician, he was considered a great teacher and contributed to the fame of the Dublin School of Medicine. For years physicians had been aware of the association between goiter, heart disease, and tachycardia. This was widely known in both the leading German- and English-speaking medical communities. Graves' original description in 1835, when he presented to the London Medical Society, was the first to describe exopthalmus as part of this condition (11). His associations paralleled those of Carl Basedow in Germany. Even today the eponym may vary depending on the native language. Graves continued his skillful lectures for many years and that helped to establish the eponym.

Alois Alzheimer was a Bavarian, born in 1864. He became a pathologist and a psychiatrist. He began observing a patient at the Frankfort Asylum for Lunatics and Epileptics in 1901. When the patient died in 1906, Alzheimer dissected the brain and, augmented by the newly developed silver stains, identified amyloid plaques and neurofibrillary tangles. He presented his findings the same year. The dementia became known after him when his discoveries were written in Kraepelin's German textbook, considered the standard of its time (12).

Hakaru Hashimoto was born in Japan and graduated from Kyushu University Medical School in 1907. As a young man he moved to Germany to continue his career. In 1912, he published 'A Report on Lymphomatus Goiter' (13). Years later the specimens were reviewed by American and British researchers who named the disease as Hashimoto's disease (14). Hashimoto returned home in 1916 because of World War I and became the town doctor in his hometown before succumbing to typhoid at the age of 53 in 1934.

Harvey Cushing was born in Cleveland in 1869. He received his medical education and training at Harvard, Johns Hopkins, and in Europe. He was a leading neurosurgeon of his day. He was a close associate of William Osler of Hopkins. In 1912, he reported a condition that he referred to as 'polyglandular syndrome' related to a pituitary disorder. His scientific career was interrupted by events in Europe. When the US became involved in World War I, he served with the US Expeditionary Force and practiced neurosurgery near the front lines. He treated Lt. Edward Revere Osler (Osler's son), who died of his wounds at the third battle of Ypres. In 1925, Cushing received a Pulitzer Prize for his biography of William Osler.

In 1932, he published his pituitary observations, discovering basophilic adenoma of the pituitary, which became known as Cushing's disease (15). Despite doubters, his findings and hypothesis were vindicated over time.

Burrill Crohn was born in Manhattan in 1884 and became a prominent New York City gastroenterologist. He was chief of gastroenterology at Mount Sinai Hospital in 1920. He and his colleagues identified a cohort of patients that had similar clinical manifestations not previously identified. Crohn, with Leon Ginzburg and Gordon Oppenheimer published 'Regional Ileitis: a Pathological and Clinical Entity' (16). Why Crohn was the first of the three potential lead authors, is unclear (whether by serendipity or simply by the alphabet); and

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even less clear, especially considering the clarity and descriptiveness of 'regional enteritis', was why there was an eponym. Moreover, Crohn reportedly was unhappy with the eponym. Or, perhaps he protested too much. Burrill Crohn practiced until the age of 90. He died in 1983 at 99, half a century after his landmark paper.

As noted above, I believe that these eponyms are here to stay. The remainder are, for the reasons discussed below, not likely to remain in common usage.

Hans Reiter was born near Leipzig in 1881. He studied medicine in Berlin, Paris, and London. During World War I, he observed non-gonococcal urethiritis/arthritis in a soldier. This and other cases described by Reiter led to a syndrome named for him (17). After World War I, he became an admirer of the rising political star, Adolf Hitler, and joined the Nazi party. In World War II, he became a high-ranking physician staff member and participated in criminal experimentation in prisoners, such as at the concentration camp at Buchenwald. After the war, Reiter was tried at Nuremberg and interned by the Russians and Americans. Eventually, he was released. Post-war, Reiter's syndrome became an accepted eponym of a clinical entity. However, when Reiter's wartime activities were rediscovered a campaign was initiated to disassociate his name from reactive arthritis (18).

Friederich Wegener was born in Germany in 1907. He developed into a brilliant physician and pathologist. Working in Breslau, he first described a new type of upper airways granulomatous destructive airway disease. He published cases in the German literature in 1939 (19). After World War II, a Swedish pathologist recognized it as a new disease discovered by Wegener, and named it for him. Because of Wegener's accomplishments, he was honored as a Master Clinician by the ACCP in 1989. However, in 2000, while researching a paper on Wegener, Matteson, and Woywoldt uncovered Wegener's Nazi past involving medical experiments conducted near Lodz, Poland, as well as, his membership in the SA and possible involvement in the genocide which took place in Poland during the war (20). The details of his involvement in Nazi atrocities were not as well documented as those of Reiter, but it seemed clear that he must have at least been aware of what was happening in Poland at that time. In 2002, a campaign was initiated to change the name of the disease to ANCA associated granulomatous vasculitis, and, later to granulomatosis with polyangitis. How successful this campaign has been is arguable, since in many instances the use of one of these tongue twisting terms is followed by 'meaning Wegener's.' It is not that easy to eliminate an eponym by a generation used to using it.

Thus we see in these two cases, one of the problems with eponyms is that subsequent information may reveal personal issues that are inconsistent with the honorary component attached to naming a clinical entity after an individual. As Germany was one of the centers of science in the first half of the twentieth century, it is not surprising that instances of brilliant discovery took place in that country. However, this was also the period of ghastly crimes committed in the treatment of individuals by representatives of that nation in Europe.

Munchausen's syndrome, or, factitious disorder, is, without a doubt a favorite medical eponym. While Munchausen was a historical figure – **Hieronymus Carl Friedrich Baron von Munchausen –** the good Baron Munchausen had nothing to do with discovery or description of the eponymous syndrome. He was born in Germany in 1720 to a prominent family in the nobility. He became a soldier for hire and fought in a number of military campaigns. After he retired, he became well known for entertaining at dinner parties on his estate. He liked to tell tall tales of his military adventures, often with fanciful entertaining exaggeration. Many of these tales were extensions of local folk tales, centuries old. In 1785, an anonymous publication of the tales with illustrations appeared that was unauthorized (21). The Baron was annoyed at the embarrassing use of his noble family name. Despite his efforts to suppress the series, the publications continued and became popular throughout Europe.

Richard Asher published a case series of factitious disorders in 1951 (22). He stated: 'Like the famous Baron von Munchausen, the persons affected have always travelled widely, and their stories, like those attributed to him, are both dramatic and untrue.' Even though it was a century and a half after the baron's death, the name stuck!

Conclusion

Typically, eponyms were established decades or even centuries ago and were named for individuals who were credited first with identification, description, and publication. Many of the names were fortuitously connected decades later as they were rediscovered by others. Although there have been instances where eponyms were later discarded, the survivors are by and large written in stone. Although the medical disease eponym is an archaic concept and may lead to scientific confusion, we believe that eponyms are here for the foreseeable future.

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